Provider Advisory Group
February 23, 2016
6:30pm
405 Promenade Street, Suite B

Attendees: Sam Salganik, Newell Warde, Howard Schulman, Greg Fox, Alquita ____, Lynn Hob, David Kroessler, Dieter Pohl, Alan Post, Sam Marullo, Lauren Lapolla, Secretary Roberts

I. Welcome

Secretary Roberts welcomed the providers and invited everyone around the table to introduce themselves. Today Sam Salganik from RIPIN is here today to talk to about the concept of consumer engagement and what needs to change, and what will be asked of providers and how that will impact consumers.

Secretary Roberts: The next conversation I propose for this group is behavioral health. We have a lot of work going on around attempting to improve services for our mentally ill. It impacts the whole spectrum of payers, but for us it is a huge driver of unmet needs. We are really struggling along with the providers in this issue and we would be really interested to have a conversation about what we are doing, what is happening in the private sector, but moreover to hear about how you integrate it – or don't – to get services for your patients.

Thank you to Newell and RIMS for hosting us month after month. Do you have any issues that you need attention, or are hearing from your members?
Newell Warde: Consumer engagement and patient engagement are definitely top, and it is good to hear a discussion in this room as well.

II. Consumer Engagement and Payment Reform in Healthcare – Sam Salganik, RIPIN. [Group Discussion]

Sam Salganik: The RI Parent Information Network (RIPIN) is a nonprofit organization based in Cranston, founded in 1991 by a group of parents of children with special health care needs. These parents were having trouble accessing resources, so they formed this group to train and be supportive for future parents. Started out being special education work, and has since expanded. Peer navigators who work with young children, peer navigators who work with Medicaid enrollees (not just children). We operate a health insurance assistance line to help provide access to coverage and access to care, anything like that. I am an attorney, and

since finishing law school I have been working on access to health care issues. Worked on a consumer assistance program in NY, I was legal counsel at HSRI for a year prior to its launch and now I am at RIPIN. I was asked here to speak about patient engagement, but also for me, what patients and consumers mean about payment reform and health reform. What are patients aware of or concerned about. Please speak out and engage in dialogue throughout this presentation.

We spend a significant amount of increasing dollars on health care. And our spending in the US per capita on health care we are far and away above other nations, but not with necessarily better outcomes than other nations. I have heard many people, including the Governor and the Secretary say that we want to pay for value not volume. Most of our health care works now on a fee for service pay – you perform an operation, you release a bill, you are paid. Not paying for volume means transitioning away from that, but what you are transitioning towards is a hugely open question. Have any of you thought of this?

Dieter Pohl: Didn't Medicare just come out with a statement as value measurements for certain societies?
Sam Salganik: They have – they have put out a number of quality measures they will gear towards. That is one conception of values. To fill you all in, you measure the percentage of kids in a certain age range getting immunizations they are to get, measure the percentage of diabetic adults with controlled hemoglobin. And you measure based on a baseline decide what is a good role.

Lynn Hob: In my practice we use a tool called How's your Health, and direct a statement to a patient where they need to decide if they disagree, agree or strongly agree with a Don Berwick statement, 'I get exactly the care I want and exactly the care I need when I need it.' When I need medical care it is easy, or extremely easy is an access question. If you take those practice metrics – the patient either thinks you are great, or not – the global measures correlate. You can use that one Berwick quote to measure practice value.
Sam Salganik: Do you feel you can measure your practice value fully on that?
Lynn Hob: Yes. That is the patient and the patient is who we serve – so that is truly the key.

Sam Salganik: To our specialists in the room, do you think those are good value measures who may have different metrics than family practices?
David Kroessler: Yes, I would say so.
Lynn Hob: I am not sure it stays for specialty care.

Alan Post: When are you giving the questionnaire ?

Lynn Hob: Before an annual exam with a patient who has been there for some time. It is a portal – my whole practice is available to use that portal.
Sam Salganik: Do any payers pay you for that?
Lynn Hob: That would be nice, but no.

Sam Salganik: Do payers pay you for other types of measures?
Lynn Hob: Well I am in CTC, so yes, but implementing it is taking the CAPS survey into what I have already. I have 1500 surveys, for the age 19-59 I have some repeats as they do them. I have a 70% completion rate of surveys from their email, the others at the practice as well.
David Kroessler: Do you have a way of capturing those who are dissatisfied or drop out?
Lynn Hob: I don't have many of those at all.

Sam Salganik: For those of you who are CTC, or who have other metrics – can you speak to this?
Dieter Pohl: We have PQRS, we do not have to participate, only Medicare will penalize us and it is not significant, so at this time it is cheaper for surgeons to not participate. The quality measures, are they the same as discussed. Yes of course one is you want the patient happy – but is it happy for taking only a day out of work, or is it if all of the cancer gone? If the hospital stay is unpleasant bit the treatment is good, how is that measured by the patient – that is very subjective. Pain outcomes, return to daily life, those are different things. What determines quality includes instruments used, length of stay etc., those are improving work for us surgeons, and improving value. All little steps, all quality measures are important in the big picture to make the patient healthier and safer overall. That is value to me.

Sam Salganik: It sounds like you have been involved in some of the work of putting the measures together – have many of you as well? [two attendees raise their hands]
Greg Fox: We are in the middle of a transformation as a part of a PCMH program – we are getting a lot of new boxes to click. For me it feels like a 15 year transformation period, for all the measures that are being asked of us correspond to additional paperwork. I tis a time consuming process. I would love for it to be as simple as described by Dr. Hob.
Lynn Hob: So bring up your own road? The CTC guys are happy to adopt in the measures that you receive if you have the formatting. The patient needs to do some of the lift. If you say you want to do a different process, then you can stand up for your process.

Sam Salganik: You make a good point, and it brings up my next question of to what extent have you seen patients or consumers engaged in these processes? [None]. Yeah that to me is very concerning. Value to a lot of

people right now means saving money, but I feel like some of the other goals are sometimes treated as secondary.
Secretary Roberts: Do you all see the goals being measured as tied to saving money, or tied to things not central to your work. I.E. the Hospital acquired infection, which yes costs money but leads to bad outcomes too?
Greg Fox: I would say, going back to the previous question, is there a patient part of this? It is negative. The patients spends more time looking at a doctor who is inputting into a computer and less time interacting with their doctor one on one. They are noticing it and it is not good. In terms of what we are being asked to input, i.e. Are we discussing use of translator services with this patient, which is a requirement of my PCMH participation. Despite my 99% English speaking patient population I need to check that both for the 2 month old and for the patient. I do not see that there is any benefit here to translate for our patients.
David Kroessler: The point is the more boxes to check off, the less eye contact.
Alan Post: I think the less eye contact is an issue… you listen to the patient 90% of the time they will tell you what is wrong with them, so embedded in front of the computer is complicated. I see patients all the time who complain of the same thing that we discuss here.
Greg Fox: Yes, it is a provider led program PCMH, but a provider negotiated process for insurers to pay.
Lynn Hob: The translator question, for example, is NCQA.

David Kroessler: As a psychiatrist, for the longest time I opposed the electronic health records for this reason – facing a computer vs. jotting down in a notebook. I succumbed about two years ago to the reality, and that we have to make it work for us. Yet it is I not a good measure of quality care to rate a doctor who stares at a computer.

Secretary Roberts: The computer is integral to your practice, Lynn?
Lynn Hob: Yes but I get around it. For a level 4 visit I need current factors, modern decision making , etc. – all my patients do instant medical history. They come in, they put in their issue, and they answer instantly prompted follow up questions. For pediatrics it's great, sick child vs. well child visit. There is a way to get around it if you try skillfully.
Sam Salganik: My wife is a physician and she does data entry at the end of the day.
Lynn Hob: Yes, but I say, have the patient do it. They realize you have a lot to do, they know it is there to help them, so have them take some ownership – and they are not resistant to doing so.
Secretary Roberts: I would much rather type it into a computer rather than put it into a four page clipboard.

Dieter Pohl: Your measure is subjective, and while I think that is good, but quality of care in a state/national picture, it's a bit bigger. Need the

hemoglobin A1Cs measured, the hospital acquired infections level- what are the objective measures that truly measure how good you did, then risk adjust it. But risk adjust it with precise data. Putting those together with the subjective, those are good quality measures.

Sam Salganik: There are a lot of quality measures out there that are really box checking. How many patients are screened for BMI and the appropriate range, and how many are counseled – and that is done by box checking, not input into whether the patient understood what they were told. There is also zero input into that measure to see if it had any affect.
Lynn Hob: Currentcare is going to come out with a patient facing portal, so in my practice about 95% are in CurrentCare. They have already made the link to the patient experience of care in the How's Your Health Tool. Currentcare could be used to look at clinical metrics, plus subjective quality metrics, away from checking boxes. That is one way that could get us as a state out of collective box checking-dom.

Secretary Roberts: If we connect boxes to actual practice and outcome, then you would know if they had a consult, if they had referral data. In the absence of information you ask people to check boxes.
Dieter Pohl: Doesn't the new payment model move away from these boxes? Everyone knows this isn't working, so aren't we moving forward? That is a done deal is it not?
Sam Salganik: I haven't seen it as a done deal. All the initiatives that I have seen include a set or several of quality measures, some are moving away from checking a box, and some are not. We just had a statewide group of payers, providers, and the state to go through all the measures to see them and make sure they are not duplicative, and some of them will be check the box measures, but some that will be more focused on responsibility for outcomes.
Secretary Roberts: Right, are you responsible for driving some level of change in the patients that you serve, or are you responsible for checking a box.
Lynn Hob: The other way to risk adjust is to access HealthfactsRI, the APCD, which comes with a module that can help risk adjust. There are ways.

Sam Salganik: How many of you are a part of an ACO? [One/Two attendees raise hands]
Howard Schulman: We are, as the Bristol Medical group as a part of Lifespan, but you really wouldn't know it.
Sam Marullo: That is interesting, for these won't work if the people on the ground don't know this process.
Howard Schulman: I think the overall ideal of here is a block of money for doctors, decide where best to spend it. I think that evaluating doctors

with metrics you won't get there – what you are counting doesn't count and what you can't count does. If you have trouble breathing, go see the doctor, she/he did the right thing – how do you measure that?
Sam Salganik: Right. The most important final goal we all work towards is to have as healthy a population as possible for as long as possible. How you measure towards that is complicated... If you can measure towards that on a statewide basis how do you implement it on a practice basis?

Sam Marullo: To go back to the ACO item, those who are not, can you speak as to where you are or why?
Greg Fox: We are in the process of being transitioned into one. We hear from payers that they are basically going to try to put everyone into one at some point, by changing the reimbursement structure for those who are not in it, or some other means. That is coming from a major insurer in the state (BCBSRI). There are six or seven you can be part of, and I know many are scrambling. Lynn, you have a different situation as a different practice type (micro-practice), but for me by example I would need to blow up the whole practice and start again from the beginning. I would need to drop people off of my panel, or clone myself, or recruit someone to help me. In RI I cannot recruit pediatricians to practice here as our pay rate is low, to get from here to there seems insurmountable.

Sam Salganik: Do you think that an ACO, where you take a group of patients attributed by where they historically get their care, take a best guess for cost projections and say to the doctors if you can get the cost down while hitting quality measures, you can share in the saving - how do you all feel about that?
Howard Schulman: I don't love the idea of a baseline.
Sam Salganik: That is an issue for practices on year one, and yes also an issue for the model under years 5 or 6 – if you keep getting measured what is the sustainability of that.

Dieter Pohl: Is that not what we all will have, Merit Incentive Based Payment System by 2019? This is the baseline, if you hit it, then you get a share, or if not then you lose.
Sam Salganik: Those are the two main models of value based payment – take your patient cohort and look for quality based improvement, or take your peers cohort and look for overall improvement. I think that looking at peers is a risk, as it does not account for socioeconomic factors – factors which reports show do impact patient outcomes.

Howard Schulman: I have been with a couple of practices, but with practices associated with Lifespan, so getting more patients as we are associated with a teaching hospital, but the patients are often sicker looking for second opinions or different answers.

Sam Salganik: When people talk about cherry picking in the policy world they look to hospitals saying no you cannot be here, but it is much more subtle. It is a patient who prefers to only go to teaching hospitals. Or for carriers, even with federal and state laws, many have not provided many services for the population with behavioral health needs. If you are an insurance company with a reputation for covering behavioral health better than your competitors you may attract patients with behavioral health problems, which then skews the risk pool. There are constant fights, these continue to happen, and that is something that I fear with a move towards making providers more accountable for cost.

Sam Salganik: On the upside, I am actually really exciting about payment reform and patient engagement. I think that there are three or four really important things for consumers that can come out of this. The first is to the extent is on outcomes, and getting care that keeps you healthy, that is good and patients should want that. Teamwork is big. Largely as a product of the FFS payment program it is very fragmented – if these new payment models can encourage providers to work more collaboratively and include team based care, patients would be really excited about that. Also, giving physicians the money, and saying where are the priorities that is a really powerful idea. If the payment models can get more resources to the patients who need it most, these shares savings arrangements, the obviously thing is that you find the 100 sickest patients and work with them diligently to make them healthier and improve my numbers.

Howard Schulman: As an anecdote – I went to a meeting with BCBSRI, who has a new plan wanting to have a social worker or nurse attached to the sickest five patients per groups. At the meeting I suggested that the nurse at home also would go to the meeting of the doctor and patient, and that person even if they are not a doctor, they can help translate and be sure that they can help the patient be successful. The vendor working with BCBSRI at this meeting flat out refused and I think that is a shame – that is a huge help.
Sam Salganik: I agree, RIPIN as an organization is always pushing for the care management resources should be based in primary care practices. Are they going to have BCBSRI care managers?
Howard Schulman: I am not sure, I haven't heard back further on that, but it wasn't in the vendor plan. I think coordination is key to help our patients.
Sam Salganik: As a part of an ACO, that would be another reason to want that.

Howard Schulman: One other main thing is that the Electronic Health Records (EHRs) do not communicate with each other. I know that they have said they are very serious about having EHRs share information, but

it fragments care.
Secretary Roberts: EPIC is taking over so that should help on the hospital side. If you are part of that network, that will also help practices.
Howard Schulman: I know that we continue to raise this, and interoperability is talked about but it hasn't been acted upon.
Sam Salganik: Right. I think one issue I heard in the past was that there was no incentive to put that in place. That seemingly is changing and we are moving away from.

David Kroessler: We really haven't addressed that 84% of the high cost high utilizers. Access to behavioral health is huge, and a lack of access is massive in RI. Your initial slide of value not volume, and the practice echoed here. Relative to psych and behavioral health there are few providers who take insurance and all these quality measures do not mean a thing to them. They are as busy as they want to be and do not need to take insurance. Those who do take Medicare, if they start squeezing and put the measures in place, they will start to stop covering Medicare clients. How do we reconcile that, how do we help those who have Medicare, who have NHP – how do we absorb the masses?
Secretary Roberts: We look at copying a program in Massachusetts that is about access to care. You're right a tight supply does mean that they do not have to take insurance, and it is a tough issue. What do you see?

David Kroessler: Need to create an incentive for psych to take on my volume. Ten patients a day is what they see now, when they could take on more, see 30 a day. There is a population that needs it – we need to incent them to take it.
Dieter Pohl: Obviously, monetarily, they do not need to. The only way to do it is to increase the number of psychiatrists, or expand scope of practice. Pay them enough, have enough providers.

Sam Marullo: What about psychologists?
David Kroessler: I don't think that is really the answer as they are more talk therapy, which is helpful, but there can be psychiatrists who are psychologically oriented and medically oriented. I am a medically oriented psychiatrist so I see the value of both sides. Interfacing with the primary care physicians, or specialists is key. That happens a lot – I send my notes off to the primary care physician or the surgeon very often to keep them in the loop.

Lynn Hob: It is definitely hard to find psych who take insurance. Your group, Angel Street is very accessible, and another group, but that's about it.
Howard Schulman: You are able to pay hospitals for procedures and little items, and then you have people that need psych care for a few years, and have to make up your mind where your priorities are.

Sam Salganik: And the Holy Grail is a payment structure where the money follows the priorities. A health population for as long as they can be, everyone playing together.

Secretary Roberts: We have been increasing dollars into primary care, and cutting to institutional care. Politically a challenging thing to do – not in this room, but statewide – one of the challenges for the physician community is that there are so many varied areas. Hospitals have a much more concentrated voice. In Medicaid we want to do it in a different way, rather than cut rates alone, but rather shift and improve care. Move money from one pocket into another. In the ACO equivalent we are talking about doing is one of those goals. What Coastal has done for example.

Howard Schulman: You talk about Medicaid only that's not much.
Secretary Roberts: In RI we are 280,000 in Medicaid, and we pay for half of the births in RI.
Howard Schulman: Okay good to know.
Secretary Roberts: We have 140,000 that look like the privately insured populations, but lower income then we have the special populations. It pays for a big chunk of the system. If you put us and BCBSRI together we pay for about 70% of the care.

Dieter Pohl: Hospital payments are so different – they do not mind Medicaid on the inpatient side.
Secretary Roberts: Right -on the physician side, there are FFS Medicaid and MCO Medicaid, which are different to. NHP is mostly Medicaid but they do sell private insurance on HSRI – about 15,000. The MCO NHP rate and the NHP reimbursement rates are higher than the FFS rates. There is a real desire to shift to primary care and away from institutional settings.

Howard Schulman: I know our practice has a lot of issues with finding new doctors. It is difficult to get an internist for sure.
Greg Fox: Yes, pediatricians as well. The transitions to new models will push some to retire who do not want to revisit at all.

Alan Post: If you go back to earlier slides, and to look at longevity and consuming pharmaceuticals, it doesn't add up. I think as great as our medical system is, academic medicine has been overly affected by big pharma. We spend so much but we do not have better outcomes. Just some food for thought
Secretary Roberts: I think increased access means better health, but increased utilization does not.

Secretary Roberts: We are going to need to wrap up and I am glad that you brought up the behavioral health topic. The supply of providers is a

key issue too, but I don't think RI is alone, or at the bottom of the food chain. Primary care we have put more money in across the market, so we have done some things, won't be what Mass is as our cost of living/business is lower, but I would love to have a conversation about it. BH, integration into PCP – is it working, what needs to be focused on more.

Dieter Pohl: The SIM Group?
Sam Salganik: A core set of measures that everyone in the room says in good faith they will use, and then a longer menu of measures from which people can choose, most of which are new.
Secretary Roberts: We recognize we have no control over Medicare.
Dieter Pohl: This core list is for..?
Sam Marullo: This is a voluntary from the payer point of view, hopefully they will adopt this core set.

Sam Salganik: There are many providers in this group, RI based group. I am told that in other states there have been good faith voluntary coordination, making life easier for everyone. If a year or two from now it is not being utilized then we will need to revisit.
Secretary Roberts: The payers will move to a different payment methodology. And different payers will use the measure set differently, but the goal was to have a consistent measure across payers. Not law, but rather practice.

III. Public Comment

IV. Adjourn